COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, JULY 10, 2020

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

CASE NO. INS-2020-00136

Ex Parte: In the matter of Adopting
New Rules Governing Balance Billing
for Out-of-Network Health Care Services

ORDER TO TAKE NOTICE

Section 12.1-13 of the Code of Virginia ("Code") provides that the State Corporation Commission ("Commission") shall have the power to promulgate rules and regulations in the enforcement and administration of all laws within its jurisdiction, and § 38.2-223[1] of the Code provides that the Commission may issue any rules and regulations necessary or appropriate for the administration and enforcement of Title 38.2 of the Code.

The rules and regulations issued by the Commission pursuant to § 38.2-223 of the Code are set forth in Title 14 of the Virginia Administrative Code. A copy also may be found at the Commission's website: http://scc.virginia.gov/pages/Case-Information.

The Bureau of Insurance ("Bureau") has submitted to the Commission a proposal to promulgate new rules in Chapter 405 of Title 14 of the Virginia Administrative Code entitled "Rules Governing Balance Billing for Out-of-Network Health Care Services," which are recommended to be set out at 14 VAC 5-405-10 through 14 VAC 5-405-90.

The proposed new rules are necessary as a result of action by the 2020 General Assembly, specifically Acts of Assembly Chapter 1080 (HB 1251) and Chapter 1081 (SB 172).

[1] Specific authority to adopt rules to implement the provisions of §§ 38.2-3445 through 38.2-3445.06 is also granted to the Commission in § 38.2-3445.07. This Code section becomes effective January 1, 2021.

This legislation, in part, adds §§ 38.2-3445.01 through 38.2-3445.07 to Chapter 34 of Title 38.2 of the Code. These sections, which become effective January 1, 2021, address balance billing by out-of-network providers. The provisions of the Bureau's proposed rules are intended to establish requirements and processes to carry out the provisions of these new Code sections that protect consumers from surprise balance billing from out-of-network providers for emergency health care services or nonemergency ancillary and surgical services received at an in-network facility. The proposed rules also set forth procedures for the use of arbitration between health carriers and out-of-network providers to address reimbursement disputes concerning balance billing.

NOW THE COMMISSION is of the opinion that the proposal to adopt new rules recommended to be set out at Chapter 405 of Title 14 in the Virginia Administrative Code as submitted by the Bureau should be considered for adoption with a proposed effective date on or before January 1, 2021.

Accordingly, IT IS ORDERED THAT:

(1) The proposed new rules entitled "Rules Governing Balance Billing for Out-of-Network Health Care Services," recommended to be set out at 14 VAC 5-405-10 through 14 VAC 5-405-90, are attached hereto and made a part hereof.

(2) All interested persons who desire to comment in support of or in opposition to, or request a hearing to oppose the adoption of proposed Chapter 405 shall file such comments or hearing request on or before September 1, 2020, with the Clerk of the Commission, State Corporation Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23218 and shall refer to Case No. INS-2020-00136. Interested persons desiring to submit comments electronically may do so by following the instructions at the Commission's website:

https://scc.virginia.gov/casecomments/Submit-Public-Comments. All comments shall refer to Case No. INS-2020-00136.

(3) If no written request for a hearing on the adoption of the proposed rules as outlined in this Order is received on or before September 1, 2020, the Commission, upon consideration of any comments submitted in support of or in opposition to the proposal, may adopt the proposed rules as submitted by the Bureau.

(4) The Bureau shall provide notice of the proposal to all carriers licensed in Virginia to write accident and sickness insurance and to all interested persons.

(5) The Commission's Division of Information Resources shall cause a copy of this Order, together with the proposed new rules, to be forwarded to the Virginia Registrar of Regulations for appropriate publication in the *Virginia Register of Regulations*.

(6) The Commission's Division of Information Resources shall make available this Order and the attached proposal on the Commission's website: https://scc.virginia.gov/pages/Case-Information.

(7) The Bureau shall file with the Clerk of the Commission a certificate of compliance with the notice requirements of Ordering Paragraph (4) above.

(8) This matter is continued.

A COPY hereof shall be sent by the Clerk of the Commission to: C. Meade Browder, Senior Assistant Attorney General, at MBrowder@oag.state.va.us, Office of the Attorney General, Division of Consumer Counsel, 202 N. 9th Street, 8th Floor, Richmond, Virginia 23219-3424; and a copy hereof shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Julie S. Blauvelt.

STATE CORPORATION COMMISSION, BUREAU OF INSURANCE

CHAPTER 405

RULES GOVERNING BALANCE BILLING FOR OUT-OF-NETWORK HEALTH CARE SERVICES

14VAC5-405-10. Purpose and scope.

The purpose of this chapter is to set forth rules and procedures that address balance billing and the use of arbitration between health carriers and out-of-network providers pursuant to the provisions of §§ 38.2-3445 through 38.2-3445.07 of Chapter 34 (§ 38.2-3400 *et seq.*) of Title 38.2 of the Code of Virginia. This chapter shall apply to all health benefit plans that use a provider network offered in this Commonwealth except as provided for in § 38.2-3445.06 of the Code of Virginia.

14VAC5-405-20. Definitions.

The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable cost-sharing requirements, for a covered service or item rendered by a participating provider or by a nonparticipating provider.

"Arbitrator" means an individual or entity included on a list of arbitrators approved by the commission pursuant to 14VAC5-405-40.

"Balance bill" means a bill sent to an enrollee by an out-of-network provider for health care services provided to the enrollee after the provider's billed amount is not fully reimbursed by the carrier, exclusive of applicable cost-sharing requirements.

"Child" means a son, daughter, stepchild, adopted child, including a child placed for adoption, foster child or any other child eligible for coverage under the health benefit plan.

"Clean claim" means a claim (i) that is received by the carrier within 90 days of the service being provided to the enrollee unless submission of the claim within 90 days is not possible due to the provider receiving inaccurate information about the enrollee or the enrollee's coverage; (ii) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim; and (iii) that includes appropriate Internal Revenue Service documentation necessary for the carrier to process payment. A failure by the provider to submit a clean claim will not remove the claim from being subject to this chapter.

"Commercially reasonable payment" or "commercially reasonable amount" means payments or amounts a carrier is required to reimburse a health care provider for out-of-network services pursuant to § 38.2-3445.01 of the Code of Virginia.

"Commission" means the State Corporation Commission.

"Cost-sharing requirement" means an enrollee's deductible, copayment amount, or coinsurance rate.

"Covered benefits" or "benefits" means those health care services to which an individual is entitled under the terms of a health benefit plan.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract, or plan covering the eligible employee.

"Emergency medical condition" means, regardless of the final diagnosis rendered to an enrollee, a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i)

serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency services" means with respect to an emergency medical condition (i) a medical screening examination as required under § 1867 of the Social Security Act (42 USC § 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition and (ii) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under § 1867 of the Social Security Act (42 USC § 1395dd (e)(3)) to stabilize the patient.

"Enrollee" means a policyholder, subscriber, covered person, participant or other individual covered by a health benefit plan.

"ERISA" means the Employee Retirement Income Security Act of 1974 (29 USC § 1001 *et seq.*).

"Facility" means an institution providing health care related services or a health care setting, including hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

"Geographic area" means any of the following: (i) for the purpose of determining a cost-sharing requirement under a health benefit plan, a geographic rating area established by the commission; or (ii) for the purpose of providing data to assist in determining a commercially reasonable amount and resolving payment disputes, the health planning region as defined at § 32.1-102.1 of the Code of Virginia, the geographic rating area established by the commission, or

other geographic region representative of a market for health care services as determined by a working group established pursuant to § 38.2-3445.03 of the Code of Virginia.

"Group health plan" means an employee welfare benefit plan as defined in § 3(1) of ERISA to the extent that the plan provides medical care within the meaning of § 733(a) of ERISA to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition. "Health benefit plan" does not include the "excepted benefits" as defined in § 38.2-3431 of the Code of Virginia.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

"Health care provider" or "provider" means a health care professional or facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the commission that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Initiating party" means the health carrier or out-of-network provider that requests arbitration pursuant to § 38.2-3445.02 of the Code of Virginia and 14VAC5-405-40.

"In-network" or "participating" means a provider that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing requirements.

"Managed care plan" means a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use health care providers managed, owned, under contract with, or employed by the health carrier.

"Network" means the group of participating providers providing services to a managed care plan.

"Nonprofit data services organization" means the nonprofit organization with which the Commissioner of Health negotiates and enters into contracts or agreements for the compilation, storage, analysis, and evaluation of data submitted by data suppliers pursuant to § 32.1-276.4 of the Code of Virginia.

"Offer to pay" or "payment notification" means a claim that has been adjudicated and paid by a carrier or determined by a carrier to be payable by an enrollee to an out-of-network provider for services described in subsection A of § 38.2-3445.01 of the Code of Virginia.

"Out-of-network" or "nonparticipating" means a provider that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

"Out-of-pocket maximum" or "maximum out-of-pocket" means the maximum amount an enrollee is required to pay in the form of cost-sharing requirements for covered benefits in a plan year, after which the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

"Provider group" means a group of multispecialty or single specialty health care providers who contract with a facility to exclusively provide multispecialty or single specialty health care services at the facility.

"Self-funded group health plan" means an entity providing or administering an employee welfare benefit plan, as defined in ERISA, 29 USC § 1002(1), that is self-insured or self-funded with respect to such plan and that establishes for its enrollees a network of participating providers. A self-funded group health plan also includes the state employee health plan and group health plans for local governments, local officers, teachers, and retirees, and the dependents of such employees, officers, teachers, and retirees.

"Surgical or ancillary services" means any professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services.

"Written" or "in writing" means a written communication that is only electronically transmitted.

14VAC5-405-30. Balance billing for out-of-network services.

A. Pursuant to § 38.2-3445.01 of the Code of Virginia, no out-of-network provider shall balance bill or attempt to collect payment amounts from an enrollee other than those described in subsection B of this section for:

1. Emergency services provided to an enrollee by an out-of-network provider located in Virginia; or

2. Nonemergency services provided to an enrollee at an in-network facility located in Virginia if the nonemergency services involve covered surgical or ancillary services provided by an out-of-network provider.

B. An enrollee that receives services described in subsection A of this section is obligated to pay the in-network cost-sharing requirement specified in the enrollee's or applicable group health plan contract, which shall be determined using the carrier's median in-network contracted rate for

the same or similar service in the same or similar geographic area. When there is no median in-network contracted rate for the specific services provided, the enrollee's cost-sharing requirement shall be determined as provided in § 38.2-3407.3 of the Code of Virginia. An enrollee that is enrolled in a high deductible health plan associated with a Health Savings Account or other health plan for which the carrier is prohibited from providing first-dollar coverage prior to the enrollee meeting the deductible requirement under 26 USC §223(c)(2) or any other applicable federal or state law, may be responsible for any additional amounts necessary to meet deductible requirements beyond those described in this subsection, including additional amounts pursuant to subsection E of this section and owed to the out-of-network provider in 14VAC5-405-40, but only to the extent that the deductible has not yet been met and not to exceed the deductible amount.

C. When a clean claim is received pursuant to the provisions of subsection A of this section, the health carrier shall be responsible for:

1. Providing an explanation of benefits to the enrollee and the out-of-network provider that reflects the cost-sharing requirement determined under this subsection;

2. Applying the in-network cost-sharing requirement under subsection B of this section and any cost-sharing requirement paid by the enrollee for such services toward the in-network maximum out-of-pocket payment obligation;

3. Making commercially reasonable payments for services other than cost-sharing requirements directly to the out-of-network provider without requiring the completion of any assignment of benefits or other documentation by the provider or enrollee;

4. Paying any additional amounts owed to the out-of-network provider through good faith negotiation or arbitration directly to the out-of-network provider; and

5. Making available to a provider through electronic or other method of communication generally used by a provider to verify enrollee eligibility and benefits, information regarding whether an enrollee's health benefit plan is subject to the requirements of this section.

D. If the enrollee pays the out-of-network provider an amount that exceeds the amount determined under subsection B of this section, the out-of-network provider shall be responsible for:

1. Refunding to the enrollee the excess amount that the enrollee paid to the provider within 30 business days of receipt; and

2. Paying the enrollee interest computed daily at the legal rate of interest stated in § 6.2-301 of the Code of Virginia beginning on the first calendar day after the 30 business days for any unrefunded payments.

E. The amount paid to an out-of-network provider for health care services described in subsection A of this section shall be a commercially reasonable amount. Within 30 calendar days of receipt of a clean claim from an out-of-network provider, the carrier shall offer to pay the provider a commercially reasonable amount. Disputes between the out-of-network provider and the carrier regarding the commercially reasonable amount shall be handled as follows:

1. If the out-of-network provider disputes the carrier's payment, the provider shall notify the carrier in writing no later than 30 calendar days after receipt of payment or payment notification from the carrier;

2. The carrier and provider shall have 30 calendar days from the date of the notice described in subdivision E 1 of this subsection to negotiate in good faith; and

3. If the carrier and provider do not agree to a commercially reasonable payment amount within the good faith negotiation period and either party chooses to pursue further action to resolve the dispute, the dispute shall be resolved through arbitration as provided in §

38.2-3445.02 of the Code of Virginia and 14VAC5-405-40. A carrier may not require a provider to reject or return claim payment as a condition of pursuing further arbitration.

F. A health carrier shall not be prohibited from informing enrollees in a nonemergency situation of the availability of in-network facilities that employ or contract with only in-network providers that render surgical and ancillary services.

G. The requirements of this chapter only apply to out-of-network services rendered in Virginia. A carrier's payment for covered services received outside Virginia by an out-of-network provider shall be in accordance with 45 CFR §147.138. An enrollee's payment responsibility for services received by an out-of-network provider outside Virginia may be based on such federal rules that allow balance billing.

14VAC5-405-40. Arbitration process.

A. If a good faith negotiation does not result in resolution of the dispute, the health carrier or provider may initiate arbitration by providing written notice of intent to arbitrate to the commission and the non-initiating party within 10 calendar days following completion of the good faith negotiation period. The notice shall state the initiating party's final payment offer.

B. Within 30 calendar days following receipt of the notice of intent to arbitrate, the non-initiating party shall provide its final payment offer to the initiating party. Agreement between the parties may be reached at any time in the process. The claim shall be paid within 10 calendar days and the matter closed upon agreement or after the arbitration decision.

C. The commission shall maintain a list of qualified arbitrators and each arbitrator's fixed fee on its website.

1. Within five calendar days of the notice of intent to arbitrate, the initiating party shall notify the commission of either agreement on an arbitrator from the list or that the parties cannot agree on an arbitrator.

2. If the parties cannot agree on an arbitrator, within three business days the commission shall provide the parties with the names of five arbitrators from the list. Within five calendar days, each party is responsible for reviewing the list of five arbitrators and notifying the commission if there is an apparent conflict of interest with any of the arbitrators on the list. Each party may veto up to two of the named arbitrators. If one name remains, that arbitrator shall be chosen. If more than one name remains, the commission shall choose the arbitrator from the remaining names.

3. Once the arbitrator is chosen, the commission shall notify the parties and the arbitrator within three business days.

4. The arbitrator's fee is payable within 10 calendar days of the assignment of the arbitrator with the health carrier and the provider to divide the fee equally.

D. Both parties shall agree to a nondisclosure agreement provided by the commission and executed within 10 business days following receipt of the notice of intent to arbitrate.

E. Within five calendar days after receiving notification of the final selection of an arbitrator, each party shall provide written submissions in support of its position directly to the arbitrator. Each party shall include in its written submission the evidence and methodology for asserting that the amount proposed to be paid is or is not commercially reasonable. Any party that fails to make a written submission required by this subsection without good cause shown will be in default. The arbitrator shall require the defaulting party to pay or accept the final payment offer of the non-defaulting party and may require the defaulting party to pay the entirety of the arbitrator's fee.

F. The arbitrator shall consider the following factors in reviewing the submissions of the parties and making a decision requiring payment of the final offer amount of either the initiating or non-initiating party:

1. The evidence and methodology submitted by the parties to assert that their final offer amount is reasonable;

2. Patient characteristics and the circumstances and complexity of the case, including time and place of service and type of facility, that are not already reflected in the provider's billing code for the service;

3. The arbitrator may also consider other information that a party believes is relevant as part of their original written submission including data sets developed pursuant to § 38.2-3445.03 of the Code of Virginia. The arbitrator shall not require extrinsic evidence of authenticity for admitting such data sets.

G. Within 15 calendar days after receipt of the parties' written submissions, the arbitrator shall issue a written decision requiring payment of the final offer amount of either of the parties. The arbitrator shall notify the parties and the commission of this decision. The decision shall include an explanation by the arbitrator of the basis for the decision and factors relied upon in making the decision, as well as copies of all written submissions by each party. The decision shall also include information required to be reported to the commission, including the name of the health carrier, the name of the provider, the provider's employer or business entity in which the provider has an ownership interest, the name of the facility where services were provided, and the type of health care service at issue.

H. Within 30 calendar days of receipt of the arbitrator's decision, either party may appeal to the commission in accordance with the provisions of 5VAC5-20-100 B based only on one of the following grounds: (i) the decision was substantially influenced by corruption, fraud, or other undue means; (ii) there was evident partiality, corruption, or misconduct prejudicing the rights of any party; (iii) the arbitrator exceeded his powers; or (iv) the arbitrator conducted the proceeding contrary to the provisions of § 38.2-3445.02 of the Code of Virginia and commission rules in such a way as to materially prejudice the rights of the party.

I. A single provider is permitted to bundle claims for arbitration. Multiple claims may be addressed in a single arbitration proceeding if the claims at issue (i) involve identical health carrier or administrator and provider parties; (ii) involve claims with the same or related Current Procedural Technology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, or in the case of facility services, Diagnosis Related Group (DRG) codes, Revenue Codes, or other procedural codes relevant to a particular procedure, and (iii) occur within a period of two months of one another. Provider groups are not permitted to bundle claims for arbitration if the professional providing the service is not the same.

J. All written submissions and notifications required under this section shall be submitted electronically. Individual information related to any arbitration is confidential and not subject to disclosure.

14VAC5-405-50. Arbitrator qualifications and application.

A. Any person meeting the minimum qualifications of an arbitrator may submit an application on a form prescribed by the commission. An application fee of up to $500 may be required. The commission shall review the application within 30 days of receipt and notify the arbitrator of its decision.

B. An arbitrator approved by the commission shall meet the following minimum qualifications:

1. Any professional license the arbitrator has is in good standing;

2. Training in the principles of arbitration or dispute resolution by an organization recognized by the commission;

3. Experience in matters related to medical or health care services;

4. Completion of any training made available to the applicants by the commission;

5. Experience in arbitration or dispute resolution; and

6. Any other information deemed relevant by the commission.

C. The applicant shall supply the following information to the commission as part of the application process:

1. Number of years of experience in arbitrations or dispute resolutions;

2. Number of years of experience engaging in the practice of medicine, law or administration responsible for one or more of the following issues: health care billing disputes, carrier and provider/facility contract negotiations, health services coverage disputes, or other applicable experience;

3. The names of the health carriers for which the arbitrator has conducted arbitrations or dispute resolutions;

4. Membership in an association related to healthcare, arbitration or dispute resolutions and any association training related to healthcare or arbitration/dispute resolution;

5. A list of specific areas of expertise in which the applicant conducts arbitrations;

6. Fee to be charged for arbitration that shall reflect the total amount that will be charged by the proposed arbitrator, inclusive of indirect costs, administrative fees and incidental expenses; and

7. Any other information deemed relevant by the commission.

D. Before accepting any appointment, an arbitrator shall ensure that there is no conflict of interest that would adversely impact the arbitrator's independence and impartiality in rendering a decision in the arbitration. A conflict of interest includes (i) current or recent ownership or employment of the arbitrator or a close family member by any health carrier; (ii) serves as or was employed by a physician, health care provider, or a health care facility; or (iii) has a material professional, familial, or financial conflict of interest with a party to the arbitration to which the

arbitrator is assigned. A close family member is generally a spouse, child, or other person living in your home for whom you provide more than half of their financial support.

E. An arbitrator shall ensure that arbitrations are conducted within the specified time frames and that required notices are provided in a timely manner.

F. The arbitrator shall maintain records and provide reports to the commission as requested in accordance with the requirements set out in § 38.2-3445.02 of the Code of Virginia and 14VAC5-405-40.

G. The commission shall immediately terminate the approval of an arbitrator who no longer meets the qualifications or requirements to serve as an arbitrator. Failure to disclose any known facts that a reasonable person would consider likely to affect the impartiality of the arbitrator in the arbitration proceeding shall serve as potential grounds for termination.

14VAC5-405-60. Data sets.

A. The commission shall contract with Virginia Health Information or its successor to establish a data set and business process to provide health carriers, health care providers, and arbitrators with data to assist in determining commercially reasonable payments and resolving payment disputes for out-of-network medical services rendered by health care providers. This contractor will develop the data sets and business process in collaboration with health carriers and health care providers. The data set shall be reviewed by the advisory committee established pursuant to § 32.1-276.7:1 of the Code of Virginia.

B. The 2020 data set shall be based upon the most recently available full calendar year of claims data drawn from commercial health plan claims and shall not include claims paid under Medicare or Medicaid or other claims paid on other than a fee-for-service basis. The 2020 data set shall be adjusted annually for inflation by applying the Consumer Price Index-Medical

Component as published by the Bureau of Labor Statistics of the U.S. Department of Labor to the previous year's data set.

C. The commission may request other adjustments to the data sets as it deems necessary.

14VAC5-405-70. Notification to consumers.

A. The notice of consumer rights shall be in a standard format provided by the commission and available on the commission's website.

B. A health carrier shall provide an enrollee with:

1. A clear description of the health plan's out-of-network health benefits outlined in the plan documents that also explains the circumstances under which the enrollee may have payment responsibility in excess of cost-sharing amounts for services provided out-of-network;

2. The notice of consumer rights delivered with the plan documents; and

3. An explanation of benefits containing claims from out-of-network providers that clearly indicates whether the enrollee may or may not be subject to balance billing.

C. A health carrier shall update its website and provider directory no later than 30 days after the addition or termination of a participating provider.

D. A health care facility shall provide the notice of consumer rights to an enrollee at the time any nonemergency service is scheduled and also along with the bill. A health care facility shall provide the notice of consumer rights to an enrollee with any bill for an emergency service. The notice may be provided electronically. However, a posted notice on a website will not satisfy this requirement.

E. A health care provider shall provide a notice of consumer rights upon request and post the notice on its website, along with a list of carrier provider networks with which it contracts. If no

website is available, a health care provider shall provide to each consumer a list of carrier provider networks with which it contracts and the notice of consumer rights.

14VAC5-405-80. Self-funded group health plans may opt-in.

A. A self-funded group health plan that elects to participate in §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia, shall provide notice to the commission and to the third-party administrator of the self-funded group health plan of their election decision on a form prescribed by the commission. The completed form must include an attestation that the self-funded group health plan has elected to participate in and be bound by §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia and this chapter, except as described in subsection E of this section. The form will be posted on the commission's public website for use by self-funded group health plans.

B. A self-funded group health plan that elects to opt-in shall reflect in its coverage documents its participation pursuant to subsection A of this section. The self-funded group health plan or plan administrator shall submit the required form electronically to the commission at least 30 days prior to the effective date. No other documents are required to be filed with the commission.

C. A self-funded group health plan may elect to initiate its participation on January 1st of any year or in any year on the first day of the self-funded group health plan's plan year.

D. A self-funded group health plan's election occurs on an annual basis. A group may choose to automatically renew its election to opt-in to §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia on an annual basis or it may choose to renew on an annual basis until the commission receives advance notice from the plan that it is terminating its election as of either December 31st of a calendar year or the last day of its plan year. Notices under this subsection must be submitted to the commission at least 30 days in advance of the effective date of the election to initiate participation and the effective date of the termination of participation.

E. Self-funded group health plan sponsors and their third-party administrators may develop their own internal processes related to member notification, member appeals and other functions associated with any fiduciary duty to enrollees under ERISA.

F. A list of all participating entities shall be posted on the commission's public website, to be updated at least each quarter. Posted information shall include relevant plan information.

G. A carrier that administers a self-funded group health plan shall, at the time of coverage verification, make information available to a provider of the group's participation in the provisions of this chapter.

14VAC5-405-90. Severability.

If any provision of this chapter or its application to any person or circumstance is for any reason held to be invalid by a court, the remainder of this chapter and the application of the provisions to other persons or circumstances shall not be affected.

FORMS (14VAC5-405-100)

Notice of Consumer Rights (URL to be provided)

Balance Billing Protection for Out-of-Network Services

Beginning January 1, 2021, Virginia state law protects you from "balance billing" while you're in Virginia if you receive emergency services from an out-of-network provider or nonemergency surgical or ancillary services provided by an out-of-network provider at an in-network facility.

What is balance billing?

Providers and facilities that do *not* directly contract with your health plan are referred to as "out-of-network" providers. Your health plan is generally not required to cover nonemergency care that you get from out-of-network providers. Under your health plan, you're responsible for certain cost-sharing amounts such as copayments, coinsurance and deductibles for covered services. Balance billing occurs when an out-of-network provider bills you for covered charges above your cost-sharing amounts that your plan didn't pay.

When you *cannot* be balance billed:

An out-of-network provider cannot balance bill or attempt to collect costs from you that exceed your plan's in-network cost-sharing requirements, such as copayments, coinsurance and deductibles, for the following services:

- ***Emergency services*** provided by an out-of-network provider (health care professional or facility). Your final diagnosis will not determine whether services are emergency services.
- ***Nonemergency surgical or ancillary services*** provided by an out-of-network health care professional at an in-network hospital, ambulatory surgical center, or similar facility. This includes professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and lab services.

NOTE: Your in-network cost-sharing requirement will be based on what your insurer usually pays an in-network provider. If you have a high deductible or catastrophic health plan, your deductible will be based on any additional amounts your plan must pay to the provider.

When you *can* be balance billed:

- *If you receive services from an out-of-network provider or facility in any other situation*, you may need to pay your plan's out-of-network cost-sharing amounts and may still be balance billed for costs that exceed your cost-sharing requirements and for any costs that exceed those allowed by the health plan.

Your health plan contracts with certain heath care professionals and facilities. These are called "in-network" providers. Insurers are required to advise you, via their websites or on request, which providers and facilities are in their networks. Health care professionals and facilities must also tell you which provider networks they participate in either on their website or on request. Using in-network providers may help you avoid additional costs.

This law does not apply to all health plans. It does not apply to health plans that do not provide comprehensive coverage such as short-term limited duration plans. If you get your health insurance from your employer, the law might not protect you. State employees are covered under this protection. Be sure to check your plan documents or contact your plan or health care provider for more information. Your explanation of benefits will provide specific information regarding your payment requirements.

Any amounts you are responsible for under this protection must count toward the maximum amount you must pay for in-network services. If you pay an amount that exceeds this, the provider must refund that amount with interest. If you are billed an amount that exceeds your payment responsibility stated on your explanation of benefits or you believe you've been wrongly billed, you can file a complaint with the State Corporation Commission's Virginia Bureau of Insurance at https://scc.virginia.gov/pages/File-Complaint-Consumers or call 1-877-310-6560.